****Faecal Management System

Name:

Hospital ID:

Date of Birth:

(Affix patient sticker)

- care guidelines:

Taken from the critical care FMS care bundle

|  |
| --- |
| Indication for insertion: (Tick all that apply) |

|  |  |
| --- | --- |
|  | Type 6-7 on Bristol stool chare in >1 episode in any 4-6hour period |
|  | Faecal incontinence |
|  | Potentially infected diarrhoea |
|  | Large volume and persistent diarrhoea |
|  | Reduce risk of skin breakdown caused by diarrhoea/faecal incontinence |
|  | Protection of wounds, burns and/or surgical site |

|  |
| --- |
| Must answer YES to all of the following questions in order to use FMS: |

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| The Patient is incontinent with liquid or semi-liquid stool |  |  |
| The patient is over 18 years old |  |  |
| No sensitivities or allergies to material used in the kit |  |  |
| Not had lower large bowel or rectal surgery within the last year |  |  |
| Not have suspected or confirmed rectal mucosal impairment |  |  |
| Not have any rectal or anal injury |  |  |
| Not have a confirmed rectal/anal tumour, stricture or stenosis |  |  |
| Not have faecal impaction |  |  |
| Not have haemorrhoids of significant size or symptoms |  |  |
| Not have any in dwelling rectal device eg. Thermometer or suppositories. |  |  |
| Not have a spinal cord injury above T5 – due to risk of autonomic dysreflexia  *Seek advice from spinal centre for any patient with any spinal injury* |  |  |

Patient **has capacity** and verbal consent gained *(please circle)* **YES NO**

Patient **does not have capacity** and FMS deemed to be in patient’s best interest – document in medical notes.

Date FMS inserted :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (**remove within 29 days**)

Distance black line to skin (*cm*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Balloon inflated (*mls*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Designation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| The decision to insert a faecal management system should be taken by a consultant / senior registrar and a senior nurse on duty. |

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|  |
| --- |
| Possible adverse events: |

* Loss of anal tone
* Pressure necrosis of rectal or anal mucosa
* Infection
* Bowel obstruction
* Bowel perforation
* Persistent rectal pain
* Abdominal distension
* Unable to open bowels for >48hours

|  |  |
| --- | --- |
| Manipulation and checks: | |
| Procedure | **Rationale** |
| Medical review every 24 hours – is FMS still indicated?  *– review with ward round if still required*  *– If ‘no’ then remove* | *Maximum continuous use is 29 days. FMS should be removed when no longer indicated, and ensure patient consents to FMS or best interest decision documented in medical notes.* |
| Every time FMS is handled, PPE worn and hands cleansed | *To minimise the risk of infection.* |
| White indicator bubble up at all times. | *To ensure the balloon/cuff is inflated.* |
| Every 12 hours check the distance from black line to skin maintained. | *To ensure the FMS has not migrated in/out since insertion.* |
| Every 12 hours, Balloon/Cuff deflated and re-inflated with *mls* shown on device *e.g. <30ml.* | *To ensure patency and reduce the risk of pressure damage internally from over-inflation of balloon, or movement/accidental removal from under-inflation of balloon (this volume may vary depending on the brand of the FMS).* |
| Every 12 hours FMS irrigated with 45ml of water | *To ensure patency of the device* |
| Drainage bag changed as required and output volume documented (every 24 hours or when over half full). | *To document output and to avoid overfilling and leakage of the bag.* |
| Bag secured below patient and off floor at all times. | *To allow for drainage of the device and as per trust infection control policy.* |

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(Affix patient sticker)

**- Daily Care Bundle.**

**Every 12 hours the following care plan must be completed:**

Date inserted\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Maximum continuous use of FMS is 29 days).

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Date: |  |  |  |  |  |  |  |
| Time: |  |  |  |  |  |  |  |
| **Is the FMS still required? (Y/N)**  *Review on ward round daily (if ‘No’ then remove)* |  |  |  |  |  |  |  |
| PPE worn and hands cleansed |  |  |  |  |  |  |  |
| White indicator bubble UP |  |  |  |  |  |  |  |
| Distance from black line to skin  (cm) |  |  |  |  |  |  |  |
| Balloon deflated and re-inflated\*  (using balloon port) |  |  |  |  |  |  |  |
| FMS irrigated with 45ml sterile water\*  (using irrigation port) |  |  |  |  |  |  |  |
| Drainage bag changed  (daily or when >half full, document ml on fluid chart) |  |  |  |  |  |  |  |
| Stool Type  (Type 6 or 7 – if not review if FMS required) |  |  |  |  |  |  |  |
| Bag below patient, secured and off floor. |  |  |  |  |  |  |  |
| Sign: |  |  |  |  |  |  |  |

\*Please refer to manufacturer guidance for recommended balloon inflation volume and irrigation volumes as these may vary between products.

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